Montana Medicaid
CLAIM JUMPER

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In This Issue

Coordination of Benefits Between Medicare and Medicaid

Montana Medicaid was recently informed of a policy change (Change Request 5284) by the Centers for Medicare and Medicaid Services (CMS) related to coordination of benefits efforts between Medicare and Medicaid. Historically, when Medicaid was informed of a patient's Medicare eligibility after a claim had been paid by Medicaid, ACS would bill Medicare for Part B claims and notify the provider of Part A claims so the provider could bill Medicare and return the money to Medicaid.

Because of the implementation of NPI effective March 31, 2007, Medicare will no longer accept claims from Medicaid for reimbursement. Accordingly, Montana Medicaid is implementing new policies effective immediately that will change the way claims for clients with retroactive Medicare, Part A, Part B and Part D are processed. When Medicaid is informed of a client's retroactive Medicare entitlement for which Medicaid has paid claims, ACS will notify the provider of this eligibility, reverse claims that are available for online adjustment and create a gross credit adjustment for claims that can not be adjusted online. The providers will then be responsible for billing Medicare for payment of these services. If the claim is subject to crossover, then the remaining balance will crossover to Medicaid.

This change should impact a minimal number of claims and providers. Historically, we have averaged about 20-30 Part A claims per month and 30-40 Part B claims per month. The provider types that most likely would be impacted by this change are physicians, hospitals, durable medical equipment, mid-levels, rural health centers, federally qualified health centers, mental health providers, therapists, ambulance, and pharmacies.

We realize this places a big burden on Medicaid providers. However, CMS has given us no options for developing alternative means for handling these claims. Please contact provider relations at 800-624-3958 if you have any questions.

Submitted by Russ Hill, DPHHS

Publications Reminder

It is providers' responsibility to be familiar with Medicaid manuals, fee schedules, and notices for their provider type, as well as other information published in the ***Claim Jumper*** and on the Medicaid website (mtmedicaid.org).

Improved Claims Processing Editing for Montana's Healthcare Programs

DPHHS will soon integrate Bloodhound's ClaimsGuard product into the claims processing system for Montana's Healthcare Programs. ClaimsGuard's edits are based on nationally recognized sources such as the Centers for Medicare and Medicaid (CMS), the Correct Coding Initiative (CCI), the American Medical Association (AMA) and the Current Procedure Terminology (CPT) Assistant. Integrating this product into the claims processing system for Montana's Healthcare Programs will allow national standards to be applied more consistently across all provider types, resulting in savings for these programs.

We encourage all providers to become familiar with these national standards in preparation for this change. Watch future editions of the *Claim Jumper* for more details on ClaimsGuard.

Billing During the NPI Contingency Period

A National Provider Identifier (NPI) contingency plan has been put in place, changing the NPI implementation date to October 1, 2007, for Montana's Healthcare Programs operated by ACS. This contingency plan affects how providers must complete claims submitted between now and October 1, 2007.

Paper Claims

Even though NPIs are not required until October 1, 2007, the new CMS-1450 (UB-04) must be used beginning May 23, 2007, and the revised CMS-1500 must be used beginning June 1, 2007. Claims submitted on the old forms after these dates will be returned to providers. When billing on paper to Montana's Healthcare Programs, providers must continue to use their current Medicaid provider number. Dental claims must contain current Medicaid/CHIP ID number. The following explains the fields to be used on the UB-04 and revised CMS-1500 forms.

Institutional Claims (CMS-1450 UB-04)

- Form Locator (FL) 57 must contain the billing provider's current Medicaid ID number.
- The second and third boxes in FL 76 must contain the attending provider's two-digit ID qualifier and current Medicaid ID number.

Professional Claims (CMS-1500 revised 08/05)

- Field 17a must contain the referring provider's two-digit ID qualifier and current Medicaid or Passport number.
- There will be no clinic/group billing until October 1, so providers must continue to bill with their Medicaid/CHIP/MHSP ID number in Field 33b. Fields 24 I and J will not be used until October 1, 2007.

Electronic claims

- Claims received prior to October 1, 2007, must contain current Medicaid ID numbers. Providers who are required to obtain NPIs may also include their NPI in addition to their current Medicaid number effective immediately, but the NPI will not be used in processing until October 1.

Why an EDI Trading Partner Agreement Is Required to Reenroll

All providers are strongly encouraged to sign an EDI Trading Partner Agreement as part of the current re-enrollment. This will allow providers to submit claims electronically. In addition, it will facilitate use of the Montana Access to Health web portal. Providers who do not sign the Trading Partner Agreement will not have access to verify eligibility, review claim status or perform any other secure function through the web portal. In the future, Montana's Healthcare Programs will be using the web portal to send all provider communication electronically. ACS is updating the Trading Partner Agreement to change the jurisdiction for legal proceedings regarding the agreement from Florida to Montana. If you have any questions, please contact Provider Relations as 1-800-624-3958.

Global Maternity Policy

The global maternity allowance refers to services normally provided in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. Per *CPT Assistant* (August 2002):

- Antepartum care begins with conception and ends with delivery. At each of these visits, the recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis (code 81000 or 81002) are included as part of the global obstetrical package. Therefore, these services are not reported separately.
- Delivery services include admission to the hospital, the admission history and physical exam, management of uncomplicated delivery including fetal monitoring, and integral components. It ends with the delivery of the placenta.
- Postpartum care includes hospital and office visits following vaginal or cesarean section delivery.

Services Not Included in Global Maternity

Per *CPT Assistant* (August 2002), any evaluation and management (E&M) services performed that are related to the pregnancy are included in the provision of antepartum care and should not be reported separately. Other visits or services which should be coded and reported separately include:

- Management of inpatient or outpatient medical complications not related to pregnancy.
- Management of inpatient or outpatient medical complications related to pregnancy (e.g. bleeding, preterm labor, and pregnancy-induced hypertension).
- Specialty consultation E&M services for pregnancy-related complication (e.g. diabetic consultation for gestational diabetes).
- Outpatient fetal stress/non-stress test, biophysical profile, fetal echocardiography, and maternity ultrasound to evaluate fetal well-being.
- External cephalic version with or without tocolysis
- Routine venipuncture (CPT code 36415).
- Management of surgical complications and problems of pregnancy, such as incompetent cervix, hernia repair, ovarian cyst, etc.
- Laboratory tests performed during pregnancy (excluding dipstick urinalysis).
- Administration of RH immune globulin.
- Antepartum amniocentesis, cordocentesis, chorionic villus sampling.

Compensation for anesthesia and an assistant surgeon for cesarean section deliveries are not included in the global maternity allowance.

Reporting the Global Obstetrical Package

Per the AMA's *CPT Assistant*, "The global obstetrical package is reported when a physician from a solo practice, or the same physician group practice provides the global routine obstetric care, which includes the antepartum care, delivery, and postpartum care." It is not appropriate to bill for these services separately if the total obsterical package is provided. Reporting of these services separately may occur if a physician or practice provides only portions of the obstetrical package, such as if a patient relocates or the pregnancy is terminated.

- If the patient relocates during her pregnancy, report the appropriate CPT code that defines the time period the patient was treated. For example, if the patient was only seen between 4-6 antepartum visits, report code 59425 with one unit of service. If the patient is seen one, two or three antepartum visits, then report each visit using the appropriate evaluation and management code (99201 - 99215). Please refer to your CPT book and the CPT guidelines for reporting separate services (antepartum, delivery, and postpartum care only) during the global package.
- If a patient is being treated for three antepartum visits, and then experiences a miscarriage, each visit is reported with the appropriate evaluation and management code. Do not report the global antepartum codes as the defined time periods were not met.

Multiple Gestation-Delivery Billing Guideline

When billing for multiple gestation-deliveries, use the following guidelines when billing Montana's Healthcare Programs:

Vaginal Delivery
Report CPT code 59400 for twin A and 59409 with modifier 51 for twin B.

Vaginal Delivery and Cesarean Section
Report CPT code 59409 with modifier 51 for twin A and 59510 for twin B.

Cesarean Section
Report CPT code 59510 for a standard cesarean section. If the cesarean is significantly more difficult, add modifier 22 to CPT code 59510, and submit an operative report and/or a special report with the claim. The diagnosis for multiple gestation should be indicated on the claim submitted for the delivery.

Adapted from BlueCross BlueShield of Montana Capsule News

14,250 copies of this newsletter were printed at an estimated cost of $.38 per copy, for a total cost of $5,492.49, which includes $2,514.56 for printing and $2,977.93 for distribution.

Alternative accessible formats are available by calling the DPHHS Office of Planning, Coordination and Analysis, at (406) 444-9772.

Recent Publications

The following are brief summaries of recently published Medicaid information and updates. For details and further instructions, download the complete document from www.mtmedicaid.org, the Provider Information website. Select ***Resources by Provider Type*** for a list of resources specific to your provider type. If you cannot access the information, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

Recent Publications Available on Website		
Date	**Provider Type**	**Description**
Notices		
04/16/07	Physicians, Mid-Level Practitioners, Public Health Clinics, Inpatient Hospitals, Outpatient Hospitals, FQHCs, RHCs, Indian Health Services	VFC Update
04/16/07	Physicians, Mid-Level Practitioners, Public Health Clinics, Inpatient Hospitals, Outpatient Hospitals, FQHCs, RHCs, Indian Health Services	Coverage of HPV Vaccine
04/19/07	Physician, Mid-Level Practitioners, Pharmacy	Abilify Dose Consolidation
04/20/07	School-Based Services	Montana Healthcare Schools Reenrollment With Managing Employee Social Security Number and Date of Birth
Fee Schedules		
04/18/07	Mid-Level Practitioners	Revised fee schedule
Other Resources		
04/02/07, 04/10/07, 04/16/07, 04/23/07	All Provider Types	What's New on the Site This Week
04/02/07	Pharmacy	April, May and June revised DUR Board agendas; manufacturer-submitted information for April 25 DURB review
04/10/07	Pharmacy	April, May and June revised DUR Board agendas
04/10/07	Pharmacy	Updated PDL and Quicklist
04/12/07	All Provider Types	May 2007 *Claim Jumper*
04/17/07	Pharmacy	Manufacturer-submitted information for April 25 DURB review
04/17/07	All Provider Types	Revised W-9 form added to Passport page
04/18/07	Pharmacy	Updated PDL and Quicklist
04/18/07	Pharmacy	April, May and June revised DUR Board agendas
04/19/07	Pharmacy	May and June revised DUR board agendas; updated manufacturer-submitted information for May 23 DURB review; updated Drug Class Review page
04/23/07	Pharmacy	Manufacturer-submitted information for June 27 DURB review
04/25/07	Pharmacy	Drug class reviews for May 23 DURB Review
04/25/07	All Provider Types	Revised application supplemental information added to NPI Provider Enrollment page
04/27/07	All Provider Types	News item regarding EFT Payments to Be Delayed
04/27/07	Pharmacy	Revised May DUR Board agenda
04/27/07	Pharmacy	Updated PDL and Quicklist

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Key Contacts

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Provider Relations
(800) 624-3958 (In and out-of-state)
(406) 442-1837 (Helena)
(406) 442-4402 Fax
Email: MTPRHelpdesk@ACS-inc.com
TPL (800) 624-3958 (In and out-of-state)
(406) 443-1365 (Helena)
(406) 442-0357 Fax
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-Sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 362-8312
Prior Authorization
Mountain-Pacific Quality Health Foundation (800) 262-1545
Mountain-Pacific Quality Health Foundation—DMEPOS/Medical
(406) 457-5887 local, (877) 443-4021, ext. 5887 long-distance
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

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